Pre-Employment Physical Examination Package

入职体检包

Dear Doctors / Aide:

We would like to kindly request that all applicants complete a pre-employment physical, which includes the following:

1st form:	Employee Physical Examination Report — must include Doctor's signature & stamp.	**Must fill**
2nd form:	TB Questionnaire Form (only if TB test is positive) — must be signed by doctor and aide.	**Optional**
3rd form:	Comfort Home Care Seasonal Influenza Vaccine Requirement (only if not vaccinated or declined) — must be signed by aide.	**Optional**

1. Complete Employee Physical Examination Report (within 1 year)

2. QuantiFERON (TB) lab report — negative (within 3 months); if positive, attach a copy of chest X-ray results (within 5 years) and complete the TB Questionnaire Form

3. Drug screen, with lab report attached (within 1 year) — optional unless requested

4. Rubella and Rubeola (measles) titer, with vaccination date and lab report attached

5. Influenza vaccination record. If no record, or declined, please complete the Comfort Home Care Seasonal Influenza Vaccine Requirement form (a mask must be worn while working during flu season)

It is imperative that we have copies of all lab work and reports. To make the process more convenient, please email copies to **info@comforthomecareny.com** or bring them to either of our offices at 36-42 Main St, 4th Floor, Flushing, NY 11354, or 136-40 39th Ave, Suite 501, Flushing, NY 11354.

Thank you in advance for your cooperation and prompt attention to this matter.

尊敬的医生 / 护理员：

我们希望所有申请人完成入职体检，包括以下内容：

1. 填写体检表格 Employee Physical Examination Report（1 年内）

2. QuantiFERON 结核病实验室报告 —— 阴性（3 个月内）；如呈阳性，请附胸片结果复印件（5 年内）并填写结核病问卷表

3. 尿毒试验 Drug screen，需附实验室报告（1 年内）—— 如无特别要求可选

4. 风疹和麻疹（Rubella and Rubeola）抗体检测，需附疫苗接种日期和实验室报告

5. 流感疫苗接种记录。如无接种记录或拒绝接种，请填写 Comfort Home Care 季节性流感疫苗要求表（流感季节工作时须佩戴口罩）

我们需要所有化验报告的副本。为方便起见，请将副本发送邮件至 **info@comforthomecareny.com**，或直接送至我们的任一办公室：36-42 Main St, 4th Floor, Flushing, NY 11354，或 136-40 39th Ave, Suite 501, Flushing, NY 11354。

感谢您的合作与及时配合。

Comfort HOME CARE

EMPLOYEE PHYSICAL EXAMINATION REPORT

[ ] Pre-Employment Physical Assessment	[ ] Annual Assessment	[ ] Return to Work / LOA	[ ] Other:
Name:		Marital Status: M S W D	Sex: M F
Address:		SS #:	Title:

PHYSICAL EXAMINATION

HEIGHT:		**PULSE:**	
WEIGHT:		**RESP:**	
BLOOD PRESSURE:		**TEMPERATURE:**	
HEAD/ENT:		**CARDIOVASCULAR:**	
EYES:		**MUSCULOSKELETAL:**	
NECK:		**ABDOMEN:**	
BREASTS:		**GENITOURINARY:**	
LUNGS:		**CENTRAL NERVOUS SYSTEM:**	
COMMENTS:			

LABORATORY TEST RESULTS

1st PPD/Mantoux (2nd step required if 1st is negative)	1. Date implanted: 2. Date read: Lot #:	Results (mm x mm): ____ [ ] Negative (-) [ ] Positive (+)
PPD/Mantoux 2nd step (if 1st step is negative)	1. Date implanted: 2. Date read: Lot #:	Results (mm x mm): ____ [ ] Negative (-) [ ] Positive (+)
Chest X-Ray (if 1st step PPD is positive)	Date:	Results: [ ] Negative (-) [ ] Positive (+) (please attach lab report)
Drug Screen (annually) (*attach lab report)	Date:	Results: [ ] Negative (-) [ ] Positive (+) (please attach lab report)

IMMUNIZATIONS

Rubella Titer (*attach lab report) If not immune, please provide MMR vaccine	Lab Value: 1.	[ ] Non-Immune [ ] Immune

Rubeola / Measles Titer (*attach lab report) (only if born on or after 1/1/1957) If not immune, please provide MMR vaccine	Lab Value: 1. 2.	[ ] Non-Immune [ ] Immune
Hepatitis B Vaccine	1.	2. 3.
Influenza Vaccine (annually mandatory)	Date received: Dose:	Type of vaccine: Name of administrator:
H1N1 Vaccine (mandatory when available)	Date received: Dose:	Type of vaccine: Name of administrator:

[ ] This individual is free from any health impairment that is a potential risk to the patient or other employee, or which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.
[ ] This individual is able to work with the following limitations: _____
[ ] This individual is not physically / mentally able to work (specify reason): _____
(Doctor's stamp here)

Physician Signature: _____ Lic. #: _____ Date: _____

Comfort HOME CARE

TB QUESTIONNAIRE FORM

To be completed by employee: _____ (Last Name, First Name)

1. Have you ever had a positive TB skin test or history of TB infection?	Yes ___	No ___
2. Have you ever had the BCG vaccine?	Yes ___	No ___
3. Do you have prolonged or recurrent fever?	Yes ___	No ___
4. Have you recently lost weight?	Yes ___	No ___
5. Do you have a chronic cough?	Yes ___	No ___
6. Do you cough up blood?	Yes ___	No ___
7. Do you have sweating at night?	Yes ___	No ___

8. Do you have any of the following risk factors which may substantially increase the risk of tuberculosis?

a. Silicosis (lung disease)	Yes ___	No ___
b. Gastrectomy	Yes ___	No ___
c. Intestinal bypass	Yes ___	No ___
d. Weight 10% or more below ideal body weight	Yes ___	No ___
e. Chronic renal disease	Yes ___	No ___
f. Diabetes mellitus	Yes ___	No ___
g. Hematologic disorder (e.g. leukemia or lymphoma)	Yes ___	No ___
h. Exposure to HIV or AIDS	Yes ___	No ___
i. Other malignancies: _____	Yes ___	No ___

Employee Signature: _____ Date: _____

Doctor / RN Signature: _____ License #: _____ Date: _____

Comfort HOME CARE

SEASONAL INFLUENZA VACCINE REQUIREMENT

Employee Name: _____

Pursuant to 10 NYCRR § 766.11

I understand that as an employee of a New York State Licensed Home Care Services Agency, I am strongly encouraged — but not required — to receive the annual influenza (flu) vaccine. The purpose of the vaccine is to protect myself, my patients/clients, and my colleagues from influenza illness and its complications. The flu vaccination is voluntary.

Please select one of the following:

[ ] I have already received the Influenza Vaccine.

Documentation provided by: _____ Received by: _____

[ ] I am choosing to decline the influenza vaccination for the current flu season.

Reason for declination (optional): [ ] Medical [ ] Religious [ ] Personal/Other

I understand that, pursuant to New York State Department of Health regulation 10 NYCRR § 766.11, any employee who provides direct patient contact and who declines the influenza vaccination must wear a surgical or procedure mask during the influenza season, as defined by the Commissioner of Health.

By signing below, I acknowledge that I have been informed of the voluntary nature of the influenza vaccination, the benefits and risks of the influenza vaccination, and the requirement to wear a mask during the influenza season if I decline vaccination.

[ ] I have received surgical/procedural masks from Comfort Home Care to be worn at all times during the influenza season while providing direct patient services.

Employee Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____